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Venereophobia- Sexually Transmitted Disease

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Abstract

Venereophobia is irrational fear of contracting venereal disease following an isolated or multiple episodes of sexual intercourse. It is a condition that is observed mostly in males. This has a major bearing on the mental as well as sexual health. While the diagnosis is easy, the treatment is usually difficult. Repeated periodic reassurances are necessary during the course of treatment. Psychiatric consultation is essential, and a joint approach forms the cornerstone of management. So far, there is no published data available in literature on the prevalence and extent of the problem.

Keywords: Venereal disease; Sexually transmitted disease; Phobia; Venereophobia

Introduction

Venereophobia is defined as an exaggerated or irrational fear of contracting venereal disease following an isolated or multiple episodes of sexual intercourse. Owing to the fact that it is a lesser known entity, very few cases are recognized and equally less reported. There is paucity of recent studies. However a study done in 1998 about frequency of sexual dysfunctions in patients attending a sex therapy clinic in north India showed venereophobia in 13% patients [1]. It is a condition that is observed mostly in males. This may be due to the signs and symptoms of venereal disease being more apparent in the male and not necessarily because that males worry more over the consequences of illicit sexual intercourse. Moreover, the external genitalia of a male can be easily viewed and frequently manipulated unlike in females. It has been observed in clinical practice that females usually deny having sexual contact prior to marriage or extramarital affair and hence venereophobia is not expressed in open frequently.

A considerable number of patients present to the dermatology clinic, or more specifically to the sexually transmitted infections (STI) clinic with doubts and fears arising from sexual contact or from lesions on genitalia, that are prima facie benign but lead to a heightened state of disquietude to the affected individual who believes them to be as a result of an STI. While the diagnosis seems easy, the treatment is usually difficult. It is a tricky and underestimated condition that is often difficult to manage. The reason for it being a thought content disorder, where there is no actual true infection unlike a classical STI, where there are more obvious signs and symptoms as well as evident therapeutic cure on instituting full course of treatment. Consequently the consternation of acquiring a venereal disease plays a major impact on the mental and reproductive health of the foreboding individual.

On basis of this article further new studies can be done to substantiate the data. The analysis attempted in this paper can be a good start for a much detailed study that could be done carefully.

Venereophobia: The Ambit of the Problem

While estimates and data regarding the prevalence and the extent of STIs are plenty, no published material exists pertaining to the incidence of venereophobia. There is no denying, however, that an increasing number of apprehensive individuals, particularly in the premarital age group, come to the STI clinic for a voluntary check up to seek multiple consultations and undergo varied tests in the pursuit for a cause and treatment that would lead to its "cure." No explanation or demonstration howsoever rational satisfies them at the first interaction. The patient has probably read all the popular literature on the subject of venereal disease which was accessible and understandable to him. In most cases he has been looking out for symptoms and signs, and he has invariably and most often virtually found one or more signs which he firmly believes to be evidence of venereal disease. On most occasions he has probably found some normal anatomical variation or phenomenon of which he himself was previously unaware.

Assessment of the patient

History: A thorough and detailed history is extremely important to arrive at the diagnosis of venereophobia. The male patient typically presents to the outpatient clinic for a voluntary checkup. A history of sexual intercourse, whether consensual or not whether protected or unprotected, such as a visit to a commercial sex worker or sexual abuse is often the inciting event. A felonious conscience soon leads to a whirlpool of fear and doubt which encompasses the patient. The fear of impending venereal infection haunts him continuously, and he explores more and more for signs and symptoms of some infection or the other to sustain his apprehensions and bring them to logical end.

The presenting complaint is usually that of asymptomatic papules on the external genitalia, discharge of semen or viscous fluid along with urine or involuntary discharge of semen also known as spermatorrhea [2]. Visible anxiety is written all over the face of the patient.

He presents with irrational fear of having contracted an STI. Repeated queries are made with the treating physician regarding the presenting complaint and its predicted fallouts and all judicious efforts to reassure the patient are seldom helpful.

It has been observed that often the patient gets biochemical investigations on his own prior to presenting himself to clinician. Negative tests such as a negative serology for HIV or nonreactive venereal disease research laboratory (VDRL) fail to convince him that there is absence of infection. Rather, due to myriad doubts and jitters working in his mind, he resorts to undergo multiple laboratory tests in the hope of convincing the physician of having contracted some infection by his episode of earlier sexual contact. This behaviour stems from having had a history of sexual contact in the past, irrespective of the number of times or partners. The patient starts examining the external genitalia repeatedly, watching out for any signs and symptoms related to the genital organs. It is at this point of time that anatomical variations or presentations which were previously unapparent or insignificant come to his notice in forefront and vicious cycle of fear starts to snowball in his thoughts and action.

Spectrum of presentation: Patients usually gives history of protected or unprotected sexual contacts or STD within short period of onset of their symptoms. They usually develop headache and pathological fear of impending venereal disease. The subconscious conflict of shame and guilt manifests as multiple somatic complaints at the conscious level. Patients invariably move from one clinic to another clinic with persistent complaints pointing to genitalia and become victims to various forms of treatment which neither lead to improvement nor cure. They are unable to get rid of their subconscious conflicts or experience of subjective compulsion [3].

Patient usually has one or more of the following symptoms, (i) unwarranted fear of venereal disease (ii) Feeling of panic (iii) Feeling of terror (iv) Feeling of dread (v) Rapid heartbeat (vi) Shortness of breath (vii) Nausea/retching (viii) Dry mouth (ix) Blurring of vision (x) Trembling (xi) Anxiety (xii) Insomnia (xiii) Excessive perspiration (xiv) Inability to perform sexual act with spouse (xv) Generalised weakness (xvi) Anorexia (xvi) Social withdrawal.

Some of the common signs and symptoms of presentation are namely:

1. Spermatorrhea: This is defined as an involuntary discharge of semen, usually encountered after the act of defecation. It is perhaps an indication of recent sexual activity and/or due to complaints of constipation. This symptom of occasional sperm fluid loss causes a matter of great concern in the young male [2].
2. Pearly penile papules (PPP): Clinically, PPP are asymptomatic, multiple, smooth, dome shaped and flesh coloured papules present circumferentially at the sulcus or corona of glans penis. It is mostly seen in uncircumscribed males in 20-30 years age group and has incidence of even 50%. It is disproportional to extent of sexual activity. They persist throughout life and usually do not regress on their own [4].
3. Sticky meatus: In abhorrent patient, this sign usually results from vigorous "milking" of the penile shaft. Urethritis (gonococcal or nongonococcal) must be excluded clinically and by relevant tests. A history of burning micturition, dysuria, fever, and signs of inflammation with or without inguinal adenopathy on the examination indicate for further evaluation for sexually transmitted urethritis.
4. Threads in the urine: The phobic patient will examine anything that comes out of his urethra, including to a close and careful examination of his urine as well. He often discovers threads, particularly so if he has had previous episode of either urethritis, gonococcal or nongonococcal. These fine threads are primarily cloudy mucous fibres.
5. Phosphaturia: This is usually reported by the patients as a milky discharge seen in the urinary stream particularly visualised, towards the end of micturition, as opposed to the discharge of spermatorrhea which is seen after defecation. An increased consumption of milk and milk products can lead to occasional temporary phosphaturia due to the increased presence of calcium phosphate in the urine. Metabolic and hormonal causes such as parathyroid gland abnormality must be borne in mind.
6. Hyperpigmentation of median raphe penis and scrotum: In a study of the normal variants of lesions in the male external genitalia it was observed that hyperpigmentation of the median raphe of the penis and scrotum is most commonly seen in individuals of study group [4].

7. Septic spots and warts.
8. Ducts of smegma glands.
9. Presence of smegma.
10. Superficial burns caused by strong disinfectants (acid/alkali) used topically by patients.
11. Normal sebaceous glands and prominent hair follicles of the ventral surface of the root of the penis and sometimes on the scrotum.

Other modes of presentation include Fox Fordyce spots, sebaceous hyperplasia, smegma, prominent veins, Bier's spots, skin tags, congenital and acquired melanocytic nevi, angiomas, and angiokeratomas, all of which do not produce any symptoms [5]. One or more symptoms of trepidity usually during a heightened state of anxiety may accompany the other presenting symptoms illustrated earlier.

Laboratory evaluation: The plain act of reassuring the distressed patient is invariably inadequate. A phobic patient is eager to undergo a detailed workup, including numerous laboratory investigations. These laboratory tests also help in establishing a diagnosis in the presence of an actual STI. A detailed history aids in advising relevant investigation for the patient and this is usually on individual basis.

The following are the investigations recommended in a case of venereophobia:

1. Routine urine analysis
2. VDRL
3. HIV serology
4. Urethral and rectal swabs for Gram staining and culture sensitivity [6]. Routine semen analysis and culture

Additional investigations:

1. Rectal swab, when the history is indicative of men who have sex with men (MSM)
2. Serology for Chlamydia trachomatis
3. Thyroid function tests (anxiety, sweating)
4. Electrocardiogram (palpitation)
5. Ultrasound scrotum for varicocele
6. Computed tomography/magnetic resonance imaging brain imaging for organic lesions
7. Dermoscopy as a tool to examine PPP, atypical naevi, sebaceous hyperplasia etc.
8. Skin biopsy (Fox-Fordyce, warts)
9. HPV typing for atypical skin tags
10. Colour Doppler for venous vasculature anamolies

Treatment

It is challenging and daunting task to treat a patient of venereophobia. At the initial onset of his visit, he is usually in no mood for reassurance, but after a few attendances, he gradually becomes transformed into a more receptive person. It is important that blood be taken for biochemical tests at each attendance as the patient places great importance on battery of blood tests. Any attempt to get rid of him prematurely will result in failure of the treatment and loss of patient to follow up. The physician must not be impatient at hearing out the patient's complaints and queries [7]. Successful treatment depends on the recognition and demonstration to the patient of the sign he has found and the explanation in terms which he can understand that this sign is not that of an active venereal infection. If the patient realizes that his suspicious sign has been considered delinquently by the clinician he is more likely to be satisfied than by confident reassurance of a general nature merely highlighting that he is not suffering from any venereal disease. In the latter case he thinks that something has been missed, and it might have been missed easily because it is probably a normal phenomenon, not connected with venereal disease. If the signs which worry phobic patients are known then leading questions with reference to them are put to the patient under consideration, he would readily admit to the presence of the one or more symptomology which has been troubling him and it is observed that from there onwards his attitude becomes less sceptical.

Repeated periodic reassurances are necessary during the course of treatment. One must not dismiss his doubts, irrespective of how immaterial and illogical they are, and a diagnostic workup akin to an actual sexually transmitted disease is often required. In the presence of benign physiological lesions of the male external genitalia such as PPP, ablation using cryotherapy, carbon dioxide laser, Nd:YAG laser, electrodessication with curettage and excisional surgery has led to promising outcomes. Patients with complaint of thread in urine need to be explained that these are basically due to a change in the character of the lining of the penile shaft brought about by the previous episode of infection. This will help to reassure the patient that their presence does not indicate present infection. In patient of phosphaturia if there is associated dysuria, oliguria or anuria, clinical opinion from urologist is desirable. A useful bedside test is the acetic acid test wherein by adding a few drops of acetic acid to the urine sample one can observe disappearance of cloudiness in the same.

Psychiatric consultation is essential, and a joint approach forms the cornerstone of management. Behaviour therapy, psychotherapy, cognitive-behavioural therapy (CBT) anti anxiety medications, selective serotonin reuptake inhibitors, tricyclic antidepressants, psychotherapy, cognitive behavioural, exposure therapy, relaxation techniques like controlled breathing and visualisation are the preferred modalities if conservative measures of counselling and repeated reassurances do not lead to improvement. A psychiatric intervention is desirable in such cases of more severe forms, antipsychotics are to be administered. Systemic desensitization is the commonest

form of behaviour therapy for phobia problems. The standard procedure is to provoke anxiety with a graded list of situations or suggestions and teaching a technique to obtain muscular relaxations [6,8]. Drug assisted systemic desensitization is found to give most satisfactory result in the majority of cases [9,10]. Time of desensitization is shorter with the help of drugs than without using medications. Short acting barbiturates are used to produce muscular relaxation. Antianxiety medications have favourable response to alleviate symptoms but there are inadequate studies in support of this modality of treatment in case of specific phobias.

Having questioned the patient and arriving at a diagnosis of venereophobia after ruling out an STI, the next admissible approach is to ascertain the frequency of follow ups and the duration required for session of counselling. While this is highly variable and depends on the progress of the patient on each follow up visit, it can be assessed mainly in two ways. One, following procedural intervention wherein the patient sees no evidence of his disease as in the case of PPP and secondly when he attains a gradual sense of relief at subsequent follow ups with a willingness to listen to the treating physician. This is perceived as a positive sign toward recovery and decreased need for subsequent follow ups is comparatively decreased.

Conclusion

It may be safe to presume that the majority of venereophobias do not actually have an underlying pathological cause or any organic lesion with no concomitant personal history of any psychiatric illness. It is a benign fear and apprehension arising out of poor understanding of venereal diseases that snowballs into a much bigger proportion. This is fuelled by half knowledge from internet, inputs from friends and acquaintances and other self misinterpretation and factually wrong analysis of facts in social circles. Expectedly, it is the vulnerable and adventurous population of adolescents that have a high risk of developing venereophobia. One of the counter measure is to incorporate timely relevant and adequate sex education in the school and college curriculum so as to target early the population who are mostly affected by venereophobia. Patience, perseverance, patients laboratory investigation, psychiatric intervention by counselling or medication and prolonged follow up are the 5 P's involved in managing a male patient of venereophobia.

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